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# INTERIM REPORT TO CONGRESS:

# EVALUATION OF THE SOCIAL/HMO DEMONSTRATION

- 1986 -

# REPORT TO CONGRESS
## on the
## SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION

### BACKGROUND

In the spring of 1980, the Health Care Financing Administration (HCFA) awarded a 3-year planning grant to the University Health Policy Consortium (UHPC) at Brandeis University to develop the concept of a Social Health Maintenance Organization (SHMO). The SHMO is a managed system of health and long term care services. Under this model, a single provider entity assumes responsibility for a full range of acute inpatient, ambulatory, rehabilitative, extended care, home health, and personal care services under a fixed budget which is prospectively determined. Elderly persons who reside in the target service area are voluntarily enrolled through the marketing efforts of the SHMO. Once enrolled, they are obligated to receive all SHMO covered services through SHMO providers, similar to operations in a medical model health maintenance organization.

The innovative features of the SHMO model are:

- Comprehensive health and community-based long term care benefits.

- All needed services are provided to beneficiaries within the capitated rate, subject to risk-sharing for the first two years. By the third year of the project, the sites will assume 100 percent of the risk.

- Consolidation of health and social services under central case management in one organized delivery system.

- Voluntary enrollment of a broad cross-section of the elderly population.

- Active participation of State Medicaid recipients, including those at risk of institutionalization.

- Pooled private and public financing of long term care services.

- Waivers of existing regulatory requirements in the Medicare and Medicaid programs which constrain integrated delivery of care.

- Extension of insurance model to long term care services.

During the first 3-year grant UHPC has refined the core benefit package; estimated costs for the long term care benefits; detailed a target case-mix based upon a disability classification scheme; developed a model waiver package; and prepared detailed working papers on reimbursement, capitation methodology, marketing and enrollment, management information system, case management, resource allocation models, provider contracts and organization design.

UHPC also developed criteria for demonstration site selection. These specifications were shared with over 40 interested providers from across the country, more than a dozen of whom submitted formal applications for site designation. Four sites were finally selected:

- Kaiser-Portland Health Plan (Kaiser), Oregon: an established HMO that will develop and/or contract for long-term and community care services;
- Metropolitan Jewish Geriatric Center (Elderplan), Brooklyn, New York: a community-based long term care agency contracting with a newly-formed gerontological medical group and community hospitals for medical services;
- Ebenezer Society-Group Health Plan (Ebenezer), Minneapolis, Minnesota: a community-based long term care agency that entered into a partnership with an established HMO for medical services;
- Senior Care Action Network (SCAN), Long Beach, California: a community case management brokerage agency which will join with a large group practice and a community hospital.

## DESCRIPTION OF THE DEMONSTRATION

All four sites have been set up to test essentially the same protocol. A description of each site, detailing specifics of the benefit package, Medicaid reimbursement, and other unique site-specific characteristics, is provided in Appendix A of this report. Incorporating the developmental work undertaken by UHPC, the sites use a common assessment instrument, offer the same core benefit package, are reimbursed in the same fashion, market to similar populations, and accept increasing risk as the demonstration matures. In addition, all sites will share common demonstration data with HCFA's independent evaluator.

### Benefit Package

The SHMO benefit package includes the normal Medicare benefit package, plus additional long term care and other supplemental benefits. The long term care benefits for those members who require them include additional skilled nursing facility (SNF) care or equivalent intermediate care facility services per year; in-home support services, such as homemaker, personal health aide, medical transportation, medical day treatment, respite care; and coordination of other services such as additional transportation needs. These long term care benefits will be covered, depending on the site, up to a maximum dollar amount per year plus a copayment.

## Financing of the SHMO

Reimbursement from Medicare (for all enrollees), Medicaid (for eligibles), and private enrollees (for non-Medicaid eligibles) will be pooled by the SHMO. Medicare will reimburse SHMOs according to what it would have cost them to purchase their regular Medicare coverage in the fee-for-service(FFS) environment, and some Medicaid agencies are also basing rates on the fee-for-service equivalent concept. Other States are using an adjusted community rate concept. In any case, the efficiencies of the SHMO model will allow SHMOs to deliver the currently covered services at costs that are less than a FFS-equivalent reimbursement level. The savings that are thereby produced will be returned to enrollees and/or third parties in the form of additional services and/or lower costs.

a. Medicare

Medicare will reimburse the SHMO at 100 percent of the AAPCC, rather than at the 95 percent level used for the Medicare competition demonstrations and as permitted under the TEFRA Medicare HMO reimbursement provision. This modification to the current methodology was used because the SHMO may be especially prone to problems of adverse selection, since it will be offering an expanded benefit package that will be particularly attractive to individuals having long-term care needs. UHPC analyses also indicate that these individuals are more likely to experience higher Medicare costs than individuals who have no need for long term care.

Reimbursement will be on the ratebook approach, with one modification. The ratebook divides all Medicare beneficiaries into three groups: (1) noninstitutionalized, nonwelfare, (2) noninstitutionalized welfare, and (3) institutionalized. Under the normal ratebook, an individual is placed into institutionalized cells only if he/she meets the following criteria:

> "Resides for over 30 days in a nursing home, sanitarium, rest home, convalescent home or long term care hospital."

Since the institutionalized cells generally receive the highest rates of reimbursement, a SHMO would have the perverse financial incentive of recommending institutionalization for an individual who could appropriately be placed either in an institution or at home (given the necessary support services). It was decided therefore to permit SHMOs to receive reimbursement at the institutional rate cell level for individuals who are determined to be "at risk" for institutionalization. It is anticipated that approximately 5 to 10 percent of enrollees will meet this level. UHPC analysis indicates that severely impaired Medicare eligibles cost approximately three times the unimpaired population. The determination of whether an individual is "at risk" for institutionalization will be performed using the State Medicaid certification forms. The sites will contract with independent organizations to validate these determinations.

b. Medicaid

Medicaid reimbursement rates are based on formulas less complex than Medicare's AAPCC since none of the participating State Medicaid agencies has been able to provide enrollee-linked spending data as current and comprehensive as data available from Medicare. Rather, initial rates have been developed on a State-by-State basis according to various concepts and methodologies. Ebenezer has developed a fee-for-service equivalent rate based on a special MMIS data run. Kaiser-Portland is proposing an adjustment of the private adjusted community rate based on Medicare spending on buy-ins (among other factors). Medicaid will pay Medicare wrap-around benefits for Medicaid enrollees on a capitation basis for the first year of the Kaiser demonstration. Long term care benefits for Medicaid enrollees will be reimbursed on a fee-for-service basis. Elderplan's methodology to calculate the Medicaid rate is a hybrid. It has some fee-for-service equivalent elements and some area community rate elements. California will determine the fee-for-service cost.

All rate proposals to Medicaid call for per capita reimbursement considerably higher than the SHMO's private premium. This reflects the greater incidence of impairment and morbidity among Medicaid eligibles as well as Medicaid's buy-out of copays for long-term care services. Most Medicaid agencies and SHMOs have also negotiated rates for a more extensive long-term care benefit for Medicaid enrollees than is available in the core benefit package.

c. Private Enrollee Payments

Private enrollee payments are the third element of the funds pool and must make up the balance of the SHMO budget after Medicare and Medicaid reimbursements are calculated. Monthly premiums have been set in the $23-$60 range, which makes them competitive with alternative Medicare supplemental insurance packages available to the elderly.

In addition, each site has devised its own levels and mechanisms for direct cost sharing by enrollees who use long term care benefits in order to raise sufficient funds to support comprehensive long-term care benefits.

Risk Sharing

Because the SHMO model is such a major departure from other HMO demonstrations in that there is insufficient data about costs, selection risk, and provider performance to support truly reliable initial cost estimates, HCFA and the States have agreed to initially permit risk sharing with the understanding that by the third year of the demonstration

all sites will be at full risk. In most sites, the risk sharing distribution will be based on the percent contribution by the various payers (Medicare, Medicaid, and private) toward the SHMO budget. The SHMO entity will be at risk for the proportion composed of private enrollee payments up to a site-specific stop loss amount.

It is important to note that SHMO entities are at some risk at the outset and that the level of risk is high enough to provide a significant incentive to carefully manage services. Contracts that SHMO entities have negotiated with providers also have risk incentive provisions. The level of risk assumed by sites will increase in year 2, and sites will be at full risk by year 3 of the demonstration.

Enrollment

The goal of the SHMO marketing effort is to enroll members on a first-come, first-served basis. The enrollment process will include widespread information dissemination through the local media, local participating provider organizations and senior organizations, community meetings, and close cooperation with HCFA and with Medicaid staff. These diverse methods are expected to avoid enrollment skewed towards a younger, healthier population. Because the SHMO will be enrolling individuals and not groups, however, and because the SHMO will offer benefits for long-term care that are not available in other insurance or health care plans, SHMO might be disproportionately attractive to elders with current chronic care needs. To protect against this result, selective queuing procedures will be allowed.

Sites will be permitted (at their discretion) to queue applicants based on their level of functional disability and/or personal care needs, e.g., (1) the well elderly and those with mild impairments, (2) those with mobility limitations which impede their independence in major activities, and (3) the severely impaired requiring extensive home health services. The distribution of these functional level categories within the enrolled SHMO population will be representative of their distribution within the community, using the best available data to estimate the community distributions. While these distributions will vary by site, it is expected that between 65-75 percent of the enrollees will be well elderly, 15-20 percent will be moderately impaired, and 5-10 percent will have severe functional limitations.

In addition to attracting the appropriate mix of enrollees, SHMOs will need to reach a full enrollment of at least 4,000 members quite rapidly--within a year of start-up. This enrollment pace is dictated by the need to reach a breakeven point as soon as possible and by the limited duration of the demonstration.

## Patient Assessment and Evaluation

All enrollees will be given an initial assessment using the Health Status Form (HSF). The HSF is a mailed questionnaire which will be completed by all SHMO enrollees as part of the initial enrollment. It will provide baseline data on the total SHMO enrollee population, as well as providing clinical indications of need for immediate medical assessment or comprehensive assessment of long term care needs. Specific questions (ADL and mobility levels) on the HSF and Application Form will be used to establish queuing categories and case mix targets. The HSF will be updated annually for all enrollees. A Comprehensive Assessment Form (CAF) will be administered to SHMO enrollees who are functionally impaired and at risk for long term care services. The CAF provides more detailed baseline information on the at-risk enrollees in the SHMO and is a clinical instrument that provides information for development of care plans. The CAF will be updated at least semiannually for enrollees receiving long term care services.

The data from the assessment forms will provide data input to the comprehensive evaluation of the SHMO demonstration. HCFA has developed the scope of work for the evaluation and anticipates selecting a contractor approximately 6 months after the implementation of the demonstration.

## Authority

Authority for conducting the demonstration derives from Section 2355 of P.L. 98-369, the Deficit Reduction Act of 1984, which mandates the Department:

> ". . . to approve, with appropriate terms and conditions as defined by the Secretary, applications or protocols submitted for waivers described in subsection (c), and the evaluation of such protocols, in order to carry out such project. Such approval shall be effected not later than 30 days after the date on which the application or protocol for a waiver is submitted or not later than 30 days after the date of the enactment of this Act in the case of an application or protocol submitted before the date of the enactment of this Act.
>
> (b) A project referred to in subsection (a) is a project-
>
> (1) to demonstrate the concept of a social health maintenance organization with the organizations as described in Project No. 18-P-97604/1-04 of the University Health Policy Consortium of Brandeis University;
>
> (2) which provides for the integration of health and social services under the direct financial management of a provider of services;
>
> (3) under which all Medicare services will be provided by or under arrangements made by the organization at a fixed annual prepaid capitation rate for Medicare of 100 percent of the adjusted average per capita cost;

(4) under which Medicaid services will be provided at a rate approved by the Secretary;

(5) under which all payors will share risk for no more than two years, with the organization being at full risk in third year;

(6) which is being provided funds under a grant provided by the Secretary of Health and Human Services; and

(7) with respect to which substantial private funds are being provided other than under the grant referred to in paragraph (5)."

Explicit waiver authority is contained in Section 402(b) of the Social Security Amendments of 1967 and Section 1115 of the Social Security Act.

On August 17,1984, HCFA approved the requisite waivers of Titles XVIII and XIX for the implementation of the SHMO demonstration, and offical notification of this approval was mailed to the four demonstration sites and the three participating State Medicaid agencies. Copies of HCFA's notification are contained in Appendix B. The terms of HCFA's approval did not require any significant changes to the protocols/applications submitted by the sites and States. The following waivers were approved:

Medicare Waivers

1. Waiver

Under Section 402(b), a waiver has been approved to permit reimbursement on a risk basis for all Medicare covered services provided to the enrolled Medicare beneficiaries under a prospectively determined rate. The prospective reimbursement rate to be paid by HCFA will be 100 percent of the AAPCC utilizing a ratebook. The ratebook approach establishes a different rate for each age, sex, Medicare category, welfare, and institutional status combination. Waiver of the usual reasonable cost and reasonable charge reimbursement provisions has been approved under section 402(b). The institutional cells will be applied both for Medicare beneficiaries who are institutionalized and those at risk of institutionalization.

Rationale

Section 402(a) permits experiments with changes in methods of payment of reimbursement, without specifying what types of organizations may be reimbursed thereunder. An experiment involving a prospectively set, risk-based capitation is clearly permissible under section 402(a). Waiver of the usual reasonable cost and reasonable charge reimbursement provisions is authorized by section 402(b).

2. Waiver

A waiver of certain coverage exclusions enumerated in Section 1862(a)(7), 1862(a)(12), and 1862(a)(13)(C) has been approved. Specifically, physical exams, eyeglasses, eye exams, dentures, routine foot care, hearing

aids and immunizations will be covered. In addition, waivers of Sections 1812, 1814(a)(2)(D), 1835(a)(2)(A), 1832, and 1861(m),(o), have been approved as they limit the Medicare scope of benefits so that the SHMO can provide prescription drugs, ICF care, and in-home support services, such as homemaker, personal health aide, medical transportation, medical day treatment, and respite care.

Rationale

Section 402(a)(1)(B) authorizes demonstrations to determine whether Medicare payment for noncovered services which are incidental to covered services would result in more economical provision and more effective utilization of services for which Medicare payments are otherwise authorized as long as the noncovered services are furnished by institutions which have the capability of providing comprehensive health care services, ambulatory health care services, or institutional services which may substitute, at a lower cost, for hospital care. The waiver is required to permit the SHMO to provide the full benefit SHMO package of comprehensive health and community based long term care services and other services essential to permit the Medicare beneficary to avoid unnecessary institutionalization. By not requiring the skilled care and homebound criteria to be satisfied, the SHMO will be able to demonstrate downward substitution of services and to increase cost efficiencies without sacrificing quality of care of the services rendered.

3. Waiver

A waiver of section 1812 and Regulations 405.110, 405.111, 405.112, 405.120, and 405.122 has been approved insofar as they limit the covered institutional services within a spell of illness or provide lifetime limitations, including those for psychiatric hospital services.

Rationale

This waiver will extend the existing Part A benefits. Part A services exceeding the section 1812 limits are noncovered services, which may be included in the demonstration under authority of section 402(a)(1)(B). The additional Part A services would be incidental to the covered Part A services rendered before the Part A benefit expires under the limitations.

4. Waiver

A waiver of section 1861(i) and Regulations 405.120, 405.126, and 405.131 has been approved to the extent they limit the use of SNF services to patients who have undergone a 3-day hospital stay within a specified period prior to their SNF admission.

Rationale

This waiver is permissible under Section 402(a)(1)(B), which allows coverage of incidental services. The SNF services would be incidental to physician services rendered to the patients for treatment of the condition requiring admission. This waiver will enable us to determine the cost efficiency of eliminating the prior hospital stay requirement.

Medicaid Waivers

Three States (New York, Minnesota, and California) submitted section 1115 applications requesting waivers for the Medicaid portion of the SHMO demonstration. These applications were reviewed by technical review panels convened by HCFA and were recommended for approval.

1. Waiver

A waiver of section 1902(a)(1) and Regulation 42 CFR 431.50(b) has been approved insofar as they require that a State Plan for Medical Assistance must " . . . be in effect in all political subdivisions of the State . . . ."

Rationale

As a HCFA national demonstration project, the SHMO is being sponsored only by four specific provider agencies. This waiver will permit the four sites to implement this project on a demonstration basis in only one area of the State.

2. Waiver

A waiver of sections 1902(a)(10) and Regulation 42 CFR 440.240 has been approved insofar as they require that a State Plan must provide that the " . . . services available . . . are not less in amount, duration and scope than those services available to a medically needy recipient . . . ."

Rationale

This waiver will enable participants in this demonstration to receive services, in addition to those provided within the context of the California, New York and Minnesota Medicaid Programs, which will not be available to Title XIX recipients who are not participating in the demonstration.

3. Waiver

A waiver of section 1902(a)(30) and Regulations 42 CFR Part 447, section 447.200 - 447.201, 447.205, 447.250 - 447.252, 447.300 - 447.302, 447.321, 447.325, and 447.342 has been approved insofar as they prescribe Federal Financial Participation (FFP) limitations and require that the State Plans stipulate that payments for services do not exceed reasonable charges consistent with efficiency, economy and quality of care. They also require public notice of change in the statewide method or level of reimbursement. Subpart C also requires that the Medicaid agency must not pay more than the upper limits described in the regulations. Regulations stipulate that institutional payments be reasonably related to actual costs and that for noninstitutional care, cost be related to comparable Medicare costs.

Rationale

Central to the operational thrust of the SHMO delivery system is the negotiation of capitated contracts with Medicaid and Medicare which will entail prospective reimbursement payments. Participating Medicaid agencies will, in addition, negotiate risk sharing arrangements with SHMO demonstration sites which will vary among the States involved.

Of primary concern to State Medicaid agencies is the ability to negotiate fixed-price arrangements with SHMO providers which will guarantee provision of a balanced, wide range of long-term care services at costs which are less than comparable costs among vendors operating in cost-reimbursed contracts. On the other hand, however, the management question affecting the SHMO entity is the ability to be free to negotiate a variety of reimbursement rates and contractual arrangements with participating providers which will facilitate smooth patient flow, service substitution, and sufficient availability of appropriate resources. This waiver is necessary, therefore, to make possible the latter contracting mechanisms while guaranteeing that the overall Medicaid budget portion of the negotiated capitation will not be exceeded. In other words, although the SHMO entity may negotiate service rates that in some cases exceed "reasonable charges," the agreed-upon overall rate is less than the Medicaid agency's overall fee-for-service alternatives.

4. Waiver

A waiver of section 1902(a)(19) and Regulation 42 CFR 435.916(c)(1) and (2) has been approved insofar as they require that eligibility be reassessed on a periodic basis.

Rationale

This waiver will provide for 6-month guaranteed eligibility for SHMO enrollees. Enrollment in the SHMO will be guaranteed for a 6-month period before eligibility redetermination is necessary. Since those

eligible for the SHMO are a relatively stable enrollment group, the provision for 6-month eligibility should be cost effective. This change is anticipated to provide an incentive for participation in the project by both providers and recipients.

5. Waiver

A waiver of section 1902(a)(23) and Regulation 42 CFR 431.51 has been approved insofar as they require that recipients may obtain services from any qualified Medicaid provider.

Rationale

New York and Minnesota requested this waiver in order to "lock-in" Medicaid SHMO enrollees. Medicaid recipients will be able to disenroll without cause during the first thirty days and disenroll during the next five months only with good cause. California did not request this waiver. The 6-month period will begin as described for guaranteed Medicaid eligibility.

In addition, under the authority of Section 1115(a)(2) of the Social Security Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of this demonstration, be regarded as expenditure under the State's Title 19 plan:

1. Expenditures to provide Medicaid benefits which would be otherwise excluded by virtue of section 1903(i)(3) and 1903(m) and 42 CFR 434.26 (the requirement that a prepaid health plan's enrollment not exceed 75 percent Medicare or Medicaid).

2. Expenditures to provide Medicaid services to individuals (for the remainder of the six-month period) who have been guaranteed six months of Medicaid eligibility at the time they enrolled in the SHMO, who were eligible for Medicaid when they enrolled, and who ceased to be eligible during the six-month period.

3. Expenditures to provide the following SHMO services to Medicaid eligibles under the demonstration, according to the State's FFP rate:

   - Adult Social Day Care
   - Housing Modifications for the Physically Impaired
   - In-Home Supportive Services
   - Respite Care
   - Meal Services for those with Special Diets
   - Special Communication

APPENDIX A

KAISER-PERMANENTE, PORTLAND

## Description of Delivery System

The Kaiser Permanente Medical Care Program is the largest nongovernmental health care provider in the world. The program provides comprehensive care to over 4.2 million persons in nine geographic areas. Kaiser has been successfully conducting a Medicare Plus HMO demonstration since 1978 in the Oregon region, which includes five counties and currently serves more than 250,000 persons, or about 20 percent of the population of the Portland-Vancouver metropolitan area. Kaiser has enrolled over 6,500 Medicare beneficiaries in their Medicare Plus, in addition to converting over 1,500 beneficiaries from their Group Prepaid Practice Contract.

Kaiser-Portland (KPMCP) maintains two hospitals, eight ambulatory care facilities, a mental health center, and three dental facilities. Physician services are provided by nearly 250 physicians in the medical group, representing most specialties. The services of specialists outside the group are obtained as required.

During the demonstration, Kaiser plans to consider adding an intermediate care facility. The provision of much of the community-based long term care services will be done under contract.

## Benefit Package

The Kaiser Social HMO benefit package includes the normal Medicare benefit package, plus additional long term care and other supplemental benefits. The additional LTC benefits include 100 days of SNF (in addition to the Medicare SNF benefit) or equivalent ICF services per year; in-home support services, such as homemaker, personal health aide, medical transportation, medical day treatment, respite care; and coordination of other services such as additional transportation needs. These in-home community support services will be covered to a maximum of $1,000 per month with 10 percent copayment, when approved by the Kaiser Resource Coordinator under a long term care plan. All services under the long term care benefit are subject to a $12,000 total maximum long term care benefit limit per year. In order to qualify for a long term care plan, a member must:

(a) Be at high risk of nursing home placement, as defined by Kaiser-Permanente using criteria derived from the State of Oregon assessment for nursing home placement, information from the CAF and from the project database, and clinical judgment;

(b) Have a long term care plan authorized by a resource coordinator;

(c) Receive services provided or arranged by the KPMCP; and

(d) Have the care plan recertified periodically as appropriate.

Kaiser will also offer the following additional services not covered by Medicare:

- Dentures - may be covered as part of the long term care benefit subject to the 10 percent copay if required as part of the in-home services.
- Prescription drugs - copayment of $1.
- Optometry - $2 visit fee.
- Audiometry - $2 visit fee.
- Eyeglasses - one pair of lenses and frame every 2 years.
- Hearing Aids - one every 2 years with $50 copay.
- Homemakers (Acute) - covered when prescribed for an acute condition; may be expanded beyond acute criteria when approved for long term care.

<u>Medicare Reimbursement</u>

Medicare reimbursement for services is based on a capitation method using a ratebook approach with one modification. As discussed in the Report, Kaiser will receive the institutional rate for all Medicare enrollees determined to be at risk of institutional care.

For reimbursement purposes, the determination of whether an individual is "at risk" for institutionalization will be performed using the State Medicaid certification forms. Kaiser will use the Oregon SSD-317, which specifies that "a client may be eligible for services under Title XIX waiver if it is established that the client requires the level of care provided in a skilled nursing facility (SNF) or intermediate care facility (ICF) and could not avoid such institutionalization if the waived services were not provided." Oregon currently uses a preadmission screening team to determine eligibility for services under the 1915(b) waivers. Under this demonstration, Kaiser and the Oregon Department of Human Resources are developing mechanisms to be used for the assessment and verification procedures. The Oregon Medical Foundation will be utilized to verify the assessment process used by Kaiser staff for the Medicare enrollees.

Medicaid Reimbursement

Kaiser has been negotiating for over a year with the State to obtain Medicaid participation in the Social HMO project. Kaiser had originally proposed a rate to the State of $74.74 per month for Medicare beneficiaries with both Parts A and B. Included in the Medicaid capitation rate had been $20 per member per month to provide for a risk stabilization fund. The fund would be used to cover losses due to excess use of services by Medicaid beneficiaries under the LTC benefit. Early during the negotiations, the State had indicated it was unwilling to enter into an open-ended risk sharing arrangement.

The negotiations resulted in the State deciding not to participate in the risk arrangement for the first year. The Senior Services Division was concerned about the capitation rate and that the assessment procedure followed by Kaiser could result in a higher percentage of Medicaid eligibles being classified as at risk for institutionalization, and therefore eligible for Medicaid long term care services. The State and Kaiser have agreed to collect data to determine an appropriate capitation for the long term care benefit. During the first year, the Medicaid-Medicare crossover population will be treated as follows:

(1) Kaiser will contract with the State to serve 500 Medicaid beneficiaries in Multnomah County with the services except the expanded long term care benefit.

(2) The State will pay a capitation rate to cover the expected costs of acute care services. Long term care services will be paid on a fee-for-service basis.

(3) HCFA will pay Kaiser 95 percent of the AAPCC for these 500 Medicaid members (instead of 100 percent) because Kaiser will not be providing capitated long term care services to this group for the first year. The "at risk" for institutionalization concept will not apply for the Medicaid population.

Before the end of the first year, the State will complete the study and make the final decision on whether to participate in the demonstration.

Risk Sharing

Because the Social HMO is a new concept for which no site has accurate utilization data, HCFA has agreed to initially permit risk sharing, with the goal of full risk by the sites during the last year of the project. In most sites, the risk sharing distribution will be based on the percent contribution by the various payers (Medicare, Medicaid, or private, with the Social HMO responsible for the private share) toward

the Social HMO budget. Since Medicaid will not be participating during the first year of the demonstration, this arrangement will not be applied with Kaiser. Furthermore, the State initially had indicated it would not consider an open-ended risk arrangement. Kaiser had proposed that the Medicaid rate with the State would include a $20 contribution toward risk stablilization. After the decision by the State not to participate during the first year, this issue became moot.

Kaiser will assume full risk for the complete benefit package, except for the expanded long term care package (which includes the home health and other community-based services, and the additional coverage of SNF and ICF care). During the first 12 months of the project HCFA will be at risk for any losses occurring because of the expanded long term care package. During the second year Kaiser and HCFA will share equally in losses on the expanded long-term care benefits. During the last year of the project, Kaiser will be at full risk for the entire Social HMO benefit package.

Enrollment and Queuing

Kaiser anticipates enrolling 4,000 Multnomah County aged Medicare beneficiaries. The enrollment will come from the following sources:

- 1500 from the general community.
- 500 Oregon SSI Medicaid recipients.
- 2000 conversions from Kaiser's current GPPP contract (non-Medicare Plus).

Medicare beneficiaries who will not be eligible to enroll include:

- Disabled.
- Aged institutionalized.
- Aged with ESRD.
- Working persons aged 65-69 or those spouses for whom Medicare coverage would be secondary.

Beneficiaries who develop ESRD will not be required to disenroll from the Social HMO; however, Kaiser will be reimbursed for ESRD services on a cost basis.

Kaiser will use a different marketing strategy for each targeted group. Marketing to the general community will be through a direct mail campaign and coordination with community senior groups. The current Kaiser enrollees will be recruited by mail on a first come, first serve basis. The SSI

population marketing program will be coordinated with the Medicaid program. The State will advise eligible Medicaid recipients of the Social HMO program and Kaiser marketing personnel will follow up to explain the program.

Kaiser plans to hold continuous open enrollment until enrollment targets are achieved., In establishing the value of the long term care benefit, Kaiser assumed that 5 percent of its enrollees would require and qualify for the benefit. Unlike the other Social HMO sites, Kaiser does not anticipate queuing to ensure that a certain mix of enrollees is achieved. Kaiser will only initiate queuing if it appears that severely impaired enrollees are exceeding 7.5 percent of enrollment.

ELDERPLAN

## Description of Delivery System

Elderplan, Inc. (Brooklyn, New York) will be directly responsible for project administration, financial management, marketing, enrollment, case management, health education and applied research in the Social HMO demonstration. This Social HMO will contract with its sponsoring agency, the Metropolitan Jewish Geriatric Center (MJGC), for long term care services, both institutional and community-based. The ancillary services of dentistry, podiatry, optometry, audiology, outpatient rehabilitation, and some transportation will be provided by MJGC. Other contracts will be made with Brooklyn Hospital-Caledonian Hospital for acute care services; Maimondes Medical Center for acute care services requiring advanced diagnostic and surgical procedures and the Geriatric Medical Associates (GMA) for primary medical care and the medical management of enrollees. The GMA physicians, physician assistants, and nurse practitioners, will operate out of a new 2,500 square foot ambulatory care center under development at MJGC's Brenner Pavilion, where an on-call system will enable enrollees 24 hour access to health providers.

## Benefit Package

Supplemental benefits to Medicare coverage provided by this plan include: actual hospital charges covered in full for an unlimited number of days; Medicare skilled nursing facility care covered in full up to 365 days in a contract year; out-of-area coverage for urgent care; full coverage of Medicare-approved services and routine physical exams, preventive immunizations, foot care (with copay), house calls by Elderplan health providers; prescription drug coverage (with copay); full Medicare dental services coverage plus extractions, dentures and denture repair ( with copay); hearing exam and hearing aid (with copay); full coverage for ambulance in case of emergency; medical transportation under some circumstances; full health education coverage; full coverage of home health care; inpatient psychiatric coverage and outpatient mental health services (with copay).

The Social HMO benefit package will include a chronic care benefit with a value of $6,500 per year for moderately and seriously impaired members who require long term support and are at-risk for institutional placement. The definition of "at-risk" will be based on information from the Comprehensive Assessment Form (see below) and existing State criteria (in New York, DMS I) for determining the need for admission to a skilled nursing facility (SNF) or intermediate care facility (ICF). All members who are found to be moderately or seriously impaired will be assigned to a case management team to monitor their status. However, only those impaired members who meet State SNF/ICF admission criteria will receive a chronic care plan prepared by the assigned case management team. All chronic care services will be prescribed on the basis of this plan. The following community-based and institutional services will be arranged, coordinated and monitored by the case management team based upon the chronic care plan:

- Nursing
- Physical, Occupational and Speech Therapies
- Personal Care and Chore Services (i.e., homemaker, housekeeper, home health aide)
- Meals
- Day Hospital
- Respite (In-Home and Institutional)
- Electronic Monitoring

The maximum benefit under a prescribed chronic care plan would be $6,500, subject to the following copays:

- Institutional care in an SNF/ICF with 20 percent copayment.
- In-Home and community support service with copay of $10 per visit (up to $200 per month).

Medicaid eligible enrollees will be covered for all premiums and copayments.

To quality for a chronic care benefit, a member must:

(a) be assessed as moderately or seriously impaired on the Comprehensive Assessment Form (CAF);

(b) meet State medical criteria for placement in an SNF or ICF;

(c) have a chronic care plan authorized by an assigned case manager;

(d) receive services provided or arranged by Elderplan; and,

(e) have the chronic care plan recertified every 90 days or when there is an observed change in the individual's health/functional status affecting the need for chronic care services.

Medicare Reimbursement

Medicare reimbursement for services is based on a capitation method using a ratebook approach with one modification. As discussed in the Report, Elderplan will receive the institutional rate for all Medicare enrollees determined to be at risk of institutional care.

Medicaid Reimbursement

During the first 18 months of the demonstration, the 840 Medicaid Social HMO enrollees will be fully Medicaid eligible, meeting both the income and resource levels established by New York State. The State will guarantee the first 6 months of client eligibility after which recipients will be reevaluated for continued eligibility. Any Medicaid recipients with excess income will be required to apply this excess toward the Medicaid premium. Under these circumstances, New York will reimburse only for the difference between the excess income and the Medicaid premium.

Medicare-only enrollees who spend down must incur the cost of the private pay Social HMO premium, plus other medical expenses equaling the amount of their excess, before Medicaid reimbursement can be applied toward other medical expenses.

Medicaid reimbursement is based on a capitation rate which covers the expected costs of all services in the current New York State Medicaid program. In other words, in addition to the Core Benefit Package, this rate will extend Social HMO coverage for Medicaid recipients to include copayments/deductibles, chronic care services for a full year, and the miscellaneous services only partially covered by the Core Benefit Package. (These miscellaneous services include routine dental and preventive dental services, some hearing exams and hearing aids more frequently than one every 2 years, some vision exams, eyeglasses more than one pair every 2 years, mental health inpatient days beyond the 190-day limit, and mental health outpatient services beyond the $500 a year limit.)

Risk Sharing

During the first project year, Elderplan, Medicare, and Medicaid will share in the risk in proportion to their respective contribution to the Social HMO budget. Elderplan's risk during the first year will be limited to $150,000. This results in the following risk-sharing distribution:

| | |
|---|---|
| Elderplan | 29 percent |
| Medicare | 53 percent |
| Medicaid | 18 percent |

If Elderplan's limit of $150,000 is reached, then Medicare will pay 80 percent and Medicaid 20 percent of the losses.

During the second year, the same distribution is used, but Elderplan's limit is raised to $500,000. Elderplan will be at full risk during the third year.

Enrollment and Queuing

Elderplan anticipates enrolling 4,000 Kings County aged Medicare beneficiaries. The enrollment will come from the following sources:

- 3,160 Medicare beneficiaries from Kings County, New York

- 840 Medicaid recipients from Kings County, New York

Medicare beneficiaries who will not be eligible to enroll include:

- o Medicare Disabled.
- o Aged institutionalized.
- o Aged with ESRD.
- o Working persons aged 65-69 or those spouses for whom Medicare coverage would be secondary.

Beneficiaries who develop ESRD will not be required to disenroll from the Social HMO. Reimbursement will be based on a separate rate cell.

Elderplan's queuing strategy is designed to accomplish two main objectives within the mandatory framework of open enrollment:

(1) The mechanism will help the Social HMO to obtain the proper proportion of enrollees, especially in terms of functional levels. The ability to obtain the proper number and mix of members is essential, as this will permit the Social HMO to spread the costs of high risk cases across a large number of enrollees so that the premium would not be too high.

(2) It will help protect the Social HMO, Medicare and Medicaid against potential adverse and positive selection, particularly with regard to the costs of the chronic care benefits. Since Elderplan will be enrolling individuals and not groups, and will offer long term care services not presently covered by other insurers or prepaid health plans, the Social HMO may be disproprotionately attractive to impaired elders. This is a very real concern for Elderplan because the market area population is older (and probably more disabled) than the average national 65 plus population. In addition, Elderplan is sponsored by a provider of care to the frail elderly, which may have an impact on the possibilities for adverse selection. Moreover, since Elderplan is not a pre-existing health maintenance organization, it does not have the advantages in recruitment of "well" older persons, or elderly of known utilization patterns.

The following quotas would be established for a 4,000 enrollment:

| | | |
|---|---|---|
| Severely Impaired | 5.5% | (220 persons) |
| Moderately Impaired | 12.0% | (480 persons) |
| Total Impaired | 17.5% | (700 persons) |
| Total "Well" Elderly | 82.5% | (3,300 persons) |
| Total | 100% | (4,000 persons) |

In order to maintain tight control on the above case mix, a phased-in approach will be utilized, that is, the above proportions will be applied to monthly marketing enrollment activity. However, if monthly enrollee case mix distributions do not match desired group targets, an attempt to adjust for the discrepancies will be made in successive monthly targets.

Elderplan plans to hold continuous open enrollment until enrollment targets are achieved. In establishing the value of the long term care benefit, Elderplan assumed that 4-6 percent of its enrollees would require and qualify for the benefit.

SCAN HEALTH PLAN

## Description of Delivery System

SCAN Health Plan in Long Beach, California will utilize a brokerage model for the delivery of Social HMO services in which three major partners will share risk for providing services. SCAN Health Plan, Inc. (SCAN) will be directly responsible for project administration, financial management, marketing, enrollment, case management (community-based services under the chronic care benefit), transportation, health education and applied research in the Social HMO demonstration. This Social HMO will contract with the St. Mary's Medical Center, The Harriman Jones Medical Clinic, Safeguard Health Plan, Long Beach Visiting Nurse Service and Family Services of Long Beach.

The St. Mary's Medical Center is a 540-bed acute care hospital designated as a level I Trauma Center by Los Angeles County. The hospital is owned by the Sisters of Charity of the Incarnate Word, Houston, Texas. The hospital will provide all institutional care and outpatient pharmacy services. It will utilize some SNF-certified beds and subcontract with Alamitos-Belmont Convalescent Hospital in order to ensure bed availability when needed.

SCAN Health Plan has established a contract with a unique physician provider group, the Harriman Jones Medical Clinic (HJC). This clinic, founded in 1930, is one of the oldest multi-speciality group practices in the country. It employs 47 physicians and is growing rapidly; a third facility has just opened, and a fourth is planned. One-third of HJC's patients are over the age of 65. Another one-third, with some overlap, are members of several area HMOs. HJC has 9 years of experience in prepaid health care delivery with a strong and effective internal utilization review process as well as a commitment to cost-effective, quality medical care. HJC will be responsible, on a capitated basis, for all physician services.

In-home support services, as well as the range of chronic and expanded plan benefits such as dentistry and optical care are being contracted for by SCAN directly. SCAN is using a basic contract format to work with the Long Beach Visiting Nurse Services and Family Services for services such as: home health and home chore services; respite and adult day care; electronic monitoring; medical transportation; home delivered meals; hearing aids; and durable medical equipment. SCAN has contracted with a State licensed, prepaid dental and optical provider, Safeguard, for comprehensive coverage. SCAN will pay Safeguard a capitated fee that is fixed for 3 years.

Benefit Package

The Social HMO benefit package covers all Medicare Part A (hospital insurance) and Part B (medical insurance) services presently available to Medicare beneficiaries. It also includes a variety of supplemental benefits, including chronic care (i.e., long-term care) services. These chronic care services significantly expand existing Medicare coverage of nursing home and in-home care.

Supplemental benefits provided by this plan include: actual hospital charges at St. Mary's Medical Center covered in full for an unlimited number of days; Medicare skilled nursing facility care covered in full up to 365 days in a contract year; out of area coverage for emergency and urgent care; full coverage of Medicare-approved services and routine physical exams, preventive immunizations, foot care (with copay), house calls by SCAN Health Plan health providers; prescription drug coverage (with copay); full Medicare dental services coverage plus extractions, dentures and denture repair (with copay); hearing exam and hearing aid (with copay); full coverage for ambulance in case of emergency; medical transportation under some circumstances; full health education coverage; full coverage for home health care; inpatient psychiatric coverage and outpatient mental health services (with copay).

The Social HMO benefit package will include a chronic care benefit with a value of $7,500 per year for moderately and seriously impaired members who require long term support and are at-risk for institutional placement. The definition of "at risk" will be based on information from the Comprehensive Assessment Form and existing State criteria (in California Screening Instrument to Determine Nursing Home Certification) for determining the need for admission to a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). All members who are found to be moderately or seriously impaired will be assigned to a case management team to monitor their status. However, only those impaired members who meet State SNF/ICF admission criteria will receive a chronic care plan prepared by the assigned case management team. Chronic care services will all be prescribed on the basis of this plan. The following community-based and institutional services will be arranged, coordinated and monitored by the case management team based upon the chronic care plan:

- Nursing Home (15% copayment after Medicare limit is exceeded)
- Physical, Occupational and Speech Therapies
- Personal Care and Chore Services including, homemaker, housekeeper, home health aides - ($5 per visit up to $100 a month)
- Meals
- Day Hospital
- Respite including In-Home ($5 per visit) and Institutional (15% copayment)
- Electronic Monitoring

Medicaid eligible enrollees will be covered for all premiums and copayments.

To qualify for a chronic care benefit, a member must:

(a) be assessed as moderately or seriously impaired on the Comprehensive Assessment Form (CAF);

(b) meet State medical criteria for placement in an SNF or ICF;

(c) have a chronic care plan authorized by an assigned case manager;

(d) receive services provided or arranged by SCAN Health Plan and,

(e) have the chronic care plan recertified every 90 days or when there is an observed change in the individual's health/functional status affecting the need for chronic care services.

Medicare Reimbursement

Medicare reimbursement for services is based on a capitation method using a ratebook approach with one modification. As discussed in the Report, SCAN will receive the institutional rate for all Medicare enrollees determined to be at risk of institutional care.

Medicaid Reimbursement

During the first year of the demonstration, the 800 Medicaid Social HMO enrollees will be fully eligible, on the basis of criteria established by the State of California.

Medicare-only enrollees who spend down must incur the cost of the private pay Social HMO premium, plus other medical expenses equaling the amount of their excess, before Medicaid reimbursement can be applied toward other medical expenses.

Reimbursement by the State is based on a capitation rate which covers the expected costs of all services except dental services in the current Medi-Cal program. In other words, in addition to the Core Benefit Package, this rate will extend Social HMO coverage for Medicaid recipients to include copayments/deductibles, chronic care services for a full year, and the miscellaneous services only partially covered by the Core Benefit Package. (These miscellaneous services include some hearing exams and hearing aides more frequently than one every 2 years, some vision exams, eyeglasses more than one pair every 2 years, mental health inpatient days beyond the 190-day limit, and mental health outpatient services beyond the $500 a year limit.) Dental services are covered under a separate Medi-Cal contract.

## Risk Sharing

SCAN Health Plan has developed a brokerage model for the delivery of services and as such it requires complex risk sharing arrangements more detailed than any of the other sites. This risk sharing arrangement has both an internal and external component. Initially, SCAN, the Harriman Jones Medical Clinics (HJC), and the St. Mary Medical Center (SMMC) have jointly developed three risk sharing pools. Within these three risk pools, SMMC is at risk for all inpatient hospital care, skilled nursing including custodial care, and, outpatient pharmacy. SCAN Health Plan is at risk for: home health care; dental; eyecare; transportation; hearing aids; durable medical equipment; out of area coverage; and administrative costs for SCAN. Lastly, the physician provider is at risk for all physician services both on an outpatient and inpatient basis, including emergency room services in area.

The three risk pools were established and funded by withholding 5 percent of SMMC's capitation payment. SCAN will contribute an amount equivalent to 10 percent of the hospital's share to each pool. HJC does not have any portion of its capitation withheld. This is then reflected in the risk sharing, as there is little benefit for HJC if utilization exceeds projections. The three risk pool levels are 1) inpatient hospital care at $15 per member per month (PMPM); 2) nursing home care at $4.77 PMPM; 3) pharmacy at $1.65 PMPM. All three of the risk pools contribute separately to a risk stabilization fund (RSF) if utilization is subsequently less than what was projected and after distribution has been made to SCAN. This RSF would remain untouched for 1 year in order to offset any operating losses occuring in the second year. If that does not happen, the first year benefits of the RSF will be divided equally among the three partners. If there is adverse utilization in the second year, the RSF would be applied proportionally to the costs of each partner's losses.

Beyond the actual risk sharing tables, SCAN does not have further responsibility to the hospital. It has agreed, though, to provide individual stop loss insurance to HJC for physician services in excess of $6,000 per individual per year. This is in order to protect HJC from extraordinary adverse selection. The hospital is assuming a maximum $600,000 risk for inpatient hospital care, skilled nursing facility, including custodial, care and outpatient pharmacy. The risk amount is based on any aggregate loss which the hospital incurs across the three risk pools. Thus if the hospital does well in one area, but loses in another, its gain/loss will offset one another, removing any disincentives for the hospital to shift patients from one area to another.

The hospital computation for achievement of stop-loss will be based on a variable per diem rate, negotiated in advance, that reflects the required level of care. The individual stop-loss coverage would take effect as soon as an enrollee's expenses for such services exceeds the ceiling of

$50,000, and subsequent utilization would be outside of the previously discussed internal risk sharing arrangements.

This stop-loss approach parallels the arrangements with the State Medi-Cal program. SCAN has reached agreement with the State that there will be an individual stop-loss level of $15,000 for all services provided to Medi-Cal members. Once this level is reached, SCAN will be reimbursed on a fee-for-service basis by the State for such individuals. As with the hospital individual stop-loss arrangements, such utilization above the $15,000 individual level will be outside of the internal risk sharing arrangements. The approach assures HCFA and SCAN that any large individual claim will not jeopardize the program even though the overall experience may be good. It represents the State's participation in the risk sharing arrangements.

These proposed individual stop-loss arrangements take precedent over the aggregate loss arrangements proposed to HCFA by SCAN. Thus, before any aggregate losses are computed, adjustment must be made for the attainment of individual stop-loss. Only after such adjustments are made can the internal risk sharing be determined, prior to utilization of external aggregate risk sharing with HCFA. Thus, the individual stop-loss benefits provided through Medicare and Medi-Cal will supersede the aggregate internal and subsequent external risk sharing relationships among the SCAN partners and Medicare.

The risk sharing arrangement proposed by SCAN is distinct from the other risk sharing arrangements proposed for Social HMOs. It has a complex, internal tripartite arrangement. It integrates an individual stop-loss approach with that of an aggregate, bottom line one. The reasoning for this is that specific areas of risk have been assumed by SMMC, SCAN and HJC complete with incentives for efficient utilization. No partner can assume the total proposed risk of $800,000, but each is prepared to deal with its own proposed level. Similarly, SCAN must conform to a certain extent with a State Medicaid system that has already developed its own mechanisms for contracting with prepaid health plans, with established patterns of risk sharing already in place.

EBENEZER/GROUP HEALTH PLAN

## DESCRIPTION OF DELIVERY SYSTEM

The Ebenezer/Group Health Plan (EB/GHP) Social HMO demonstration project will use the experience, physical resources and licensing of each sponsor to function. The Social HMO will operate under the name "Medicare Partners". The Medicare Partners contract will be offered by Group Health Plan under its certificate to operate as an HMO in Minnesota. The integration of medical and long-term care services will be accomplished through collaborative management of the program.

Together, Ebenezer and Group Health Plan have over ninety years of direct service experience. Ebenezer operates six nursing facilities at various levels of care with 670 beds. It was a pioneer in developing a psycho-social model of care in its nursing homes as opposed to a strict medical model. A significant new concept in residential long term care called a "specialized, skilled nursing facility" was put into operation by Ebenezer during 1983. In this facility, staffing levels were increased to care for chronic illness needs previously treated only in hospitals.

Ebenezer owns or manages six congregate housing facilities with 1382 units. It has conceived of its elderly housing facilities as a support system for independent living. It was one of the first agencies in the country to provide congregate dining as part of the housing complex.

Ebenezer has also responded to the needs of frail people still able to live at home with some supports. The community based programs include homemaking, home health aides, visiting nurses, adult day care and senior companions. Ebenezer will directly provide virtually all community based long term care services, but will coordinate nursing home placement with a select group of nursing homes based on their quality of care, desirability to enrollees and accessibility to acute medical care delivery sites.

The Ebenezer Society is owned by a consortium of Lutheran churches and has a history of sixty-five years service to the community. All services are available without regard to race, creed or religious affiliation.

Group Health Plan was founded in 1957 and is the oldest and largest HMO in Minnesota. Over 193,000 members are served through 11 medical clinics, five dental clinics, and several pharmacy/optical services providers.

Recently, Group Health Plan has been a leader in providing membership and benefits to AFDC families in a way that promises to save the State of Minnesota money while delivering quality care to the enrollee.

During the demonstration, the functions of membership registration (eligibility verification), direct billing, claims processing, management information system (MIS), accounting services and limited actuarial services (acute care) will be provided by Group Health Plan systems which are already in place. Where necessary, Group Health Plan staff are adapting their normal procedures to accommodate the unique needs of the Social HMO.

Acute ambulatory and hospital services will be obtained through the Group Health Plan system. These services include physician services, optometric and optical services, audiometric services, medically-related dental services, services provided by mid-level practitioners, health education, pharmacy services, and diagnostic ancillary services. Costs of services provided by outside provider groups and organizations, e.g., hospitals, referral physicians, which are used during the course of treating a Medicare Partners enrollee will be handled through existing Group Health Plan contracts.

Benefit Package

The Medicare Partners benefit package for those persons not concurrently receiving Medicaid covers all Medicare Part A and Part B services currently available to beneficiaries and most Medicare copayments and deductibles for these services. It extends the number of covered hospital days and skilled nursing facility days per benefit period, and adds other acute medical care benefits such as vision, hearing and preventive dental services. (All services must be medically necessary, as defined under current Medicare guidelines.) The benefit package also includes long term care services which significantly expand coverage of nursing home care and in-home support services. Among these is a benefit for persons determined to be at high risk of requiring nursing home placement and in need of services. This expanded service will be provided only when prescribed under a long term care plan. Persons assumed to be at high risk for nursing home placement include all persons who qualify as nursing home certifiable according to Hennepin County Preadmission Screening Program guidelines and those moderately impaired persons for whom, in the judgment of Social HMO Case Management staff, earlier intervention could prevent deterioration to nursing home certifiable status. In addition, there is a special chronic care benefit which supplements standard Medicare/Medicaid ($5,000 per year limit and $6,500 lifetime limit on SNF/ICF services).

The benefit package for those enrollees who are receiving Medical Assistance (MA) will include all of the services currently provided under the State Medicaid Plan. This will include copayments and deductibles for all Medicare services, as well as unlimited hospital days, unlimited nursing home days, and currently covered community long term care services such as home nursing services, home health aides and medical transportation.

In addition, several services not ordinarily provided through MA will be covered for those persons certified to be at high risk of nursing home placement, if required by the person's condition and authorized by the Plan's case manager. The additional services which will be available when determined to be necessary are: homemaker, medical and social day treatment, Emergency Response Communication System, respite care, and case management. Other needed support services such as those services, home delivered meals, and non-medical transportation will be arranged and coordinated when needed.

Minnesota Department of Public Welfare (MDPW) has agreed to the inclusion of a capitation rate cell for persons who qualify as nursing home certifiable. For those persons who do not meet State criteria for nursing home certifiability but in the judgment of case managers require earlier intervention to prevent deterioration to this status, savings from the Medicare AAPCC will be available to finance needed services. Arrangements are also being made with the Hennepin County Community Services Department and the local Area Agency on Aging to assure continued access to services for which these enrollees are eligible.

Special limits, copayments, and deductibles associated with benefit package include:

- o 50% copay for glasses (examination free)
- o 50% copay for hearing aid (examination free)
- o Discount rate available for dental care and denture repair (cleaning, exams, and preventive care free).
- o Prescription drugs - $2.00 for 34 day supply (separate fee for each type of drug).
- o Long Term Care - 20% copay, $5,000 per year limit. (6,500 lifetime limit on SNF/ICF services).
- o Out-patient mental health and chemical dependency services - $10.00 per visit, 20 visits per year.
- o Emergency-out-of-area - 20% copay of first $500 charges.
- o Ambulance - 20% copay.

Enrollees who develop ESRD will not be disenrolled from the project. A separate reimbursement cost based system will be established for any enrollees with this condition.

## MEDICARE REIMBURSEMENT

Medicare reimbursement for services is based on a capitation method using a ratebook approach with one modification. As discussed in the Report, Ebenezer will receive the institutional rate for all Medicare enrollees determined at risk for institutional care.

## MEDICAID REIMBURSEMENT

For enrollees in the Social HMO who have dual eligibility for Medicare and Medicaid, arrangements for participation have been developed in conjunction with the Minnesota Department of Public Welfare (MDPW). Social HMO developmental work has occurred simultaneously with development of prepayment mechanisms for the Medicaid Prepayment Demonstration Project. Efforts have been made to coordinate activities so that the two projects are compatible. Minnesota's Medicaid Management Information System (MMIS) contains detailed client-specific information which makes feasible the development of a ratebook similar to the Medicare AAPCC ratebook, based on differences in Medicaid expenditures by eligibility status, age, sex and institutional status.

The plan projects a total Medicaid enrollment of 800 members (150 institutionalized and 650 community residents).

The large number of institutional Medicaid enrollees is a unique feature of the Medicare Partners Social HMO site. MDPW payment rates for Medicare Partners enrollees will be based on the amount which the Medicaid program would have otherwise expected to spend for Social HMO enrollees if they had remained in the fee-for-service system. In addition to standard rate cell categories, there will be an adjustment for nursing home certifiable persons living in the community. In-home supportive services not currently covered by Medicare or through the regular Medicaid program will be available to this group, and will provide a test of the feasibility of using in-home services to delay the need for higher cost institutional long term care services.

RISK SHARING

The Ebenezer/Group Health site will implement the model where risk is pooled in proportion to shares in the reimbursement pool. An audited cost report will be made available to both HCFA and MDPW for purposes of determining gains or losses to be shared. It will contain a comparison of costs and revenues for Medicaid Partners, and will be available at the end of each project year.

Essential elements of the risk-sharing proposal are as follows:

(1) HCFA's initial risk exposure would be the proportion of the costs of Medicare A and B services to the total program budget (i.e., 46.4%).

(2) Medicaid's initial risk exposure would be the proportion of the costs of Medicaid services to the total program budget (i.e., 30.0%).

(3) Medicare Partners' initial risk exposure would be the proportion of the remaining costs of Social HMO services to the total program budget (i.e., 23.6%, up to a maximum of $250,000).

(4) Above this initial loss corridor, (i.e., $1,059,322), Medicare and Medicaid would share the risk according to their portion of total third-party revenues they produce (i.e., Medicare - 60.7% and Medicaid - 39.3%).

Any first-year surpluses--the differences between revenues and actual costs--will be handled in the following manner:

(1) The Social HMO would receive 23.6% of surpluses, up to a maximum level of gain of $250,000.

(2) Above this initial surplus corridor (i.e., $1,059,322), Medicare and Medicaid would share in these savings according to their proportion of total third party revenues they produce. (See the above discussion on the loss corridor). These savings would be returned to HCFA and Medicaid through a lump sum payment and/or future reimbursement adjustments.

Because actual enrollment by rate cell category may be different than the mix assumed here, the percentages may vary somewhat from the estimates provided here. Actual risk sharing percentages will be calculated at the end of the year.

Additional risk-sharing controls include:

- o Risk stabilization/reserve contingencies fund - depending on success of Social HMO to save on delivery of services, an average rate of $17.80 per member per month would be put into stabilization fund to assist providers that encounter financial problems, or increase services to members.
- o Medicaid "stop loss" coverage plan - for any member with over $30,000 annual hospital costs, MDPW will pay 80% of excess.
- o For any member in a nursing home over 90 days, MDPW will pay 80% of charges.
- o If plan costs exceed Medicaid payments, MDPW will pay 50% of cost overrun before formal end of year risk sharing settlement with Medicare, Medicaid, and EB/GHP.

<u>Enrollment and Queuing</u>

Enrollment will begin as soon as the contract between HCFA and the ES/GHP Social HMO is signed.

The pace of enrollment is projected to average about 333 new members per month during the first six months of operation and then continue at a slower pace during the second six months until an enrollment of at least 2,700 is achieved. The plan projects a total enrollment of 4,000 members.

Site staff believe that these projections are feasible, based on HMO Medicare marketing experience in the Twin Cities, market projections of Medicare Partners Market Survey, and the aggressive marketing stance and relatively open enrollment that are planned.

Project queuing poilicy is as follows:

- o Severely impaired - 3.4% Medicare only members.
- o Moderately impaired - 13.6% Medicare only members.
- o Unimpaired or mildly impaired - 83% Medicare only members.
- o Medicaid enrollees will not be included in queuing process and will be enrolled up to a maximum of 20% (800 members) of total plan membership regardless of degree of impairment.

6325 Security Boulevard
Baltimore, MD 21207

APPENDIX B

AUG 17 1984

Mr. Dennis Kodner
General Director
Elderplan, Inc.
910 48th Street
Brooklyn, New York 11219

Dear Mr. Kodner:

I am pleased to inform you that Elderplan, Inc. has been approved as one of the four provider entities participating in the Health Care Financing Administration's (HCFA) Social/Health Maintenance Organization Demonstration (Grant No. 18-P-97604/1-05).

I have enclosed a list of the waivers and variances required for participation as a Social/Health Maintenance Organization provider. These waivers and variances are approved for the period beginning October 1, 1984 and ending March 31, 1988. Also enclosed is a list of Special Terms and Conditions associated with Elderplan, Inc.'s participation in the demonstration project. Final approval for participation in the project is contingent upon our receipt, within 30 days, of a written response accepting the enclosed Special Terms and Conditions.

Communications regarding programmatic aspects of the demonstration should be addressed to the HCFA project officer, Mr. William D. Clark, Room 2-F-6, Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207. His telephone number is (301) 594-0093.

I look forward to your participation and a successful implementation of this demonstration.

Sincerely yours,

David J. Butler
Acting Director
Office of Research and Demonstrations

Enclosures

## SPECIAL TERMS AND CONDITIONS

1. The demonstration will run for 42 months, with the first year defined as lasting 18 months.

2. Enrollment will not exceed 7500 Medicare beneficiaries.

3. The SHMO will be paid through December 31, 1984 at the 1984 AAPCC. HCFA anticipates that the 1985 AAPCC will be available mid-November. The 1985 AAPCC rates will be effective January 1, 1985.

4. No more than 5 percent of the SHMO members at enrollment will be "nursing home certifiable" and living in the community.

5. Within 120 days of award, the site shall submit for HCFA review and approval a phase-down plan which will describe how the site will ensure a smooth transition during the last year of the project. The phase-down plan must include a provision that no SHMO enrollment will be permitted during the last 9 months of the last year.

6. The site will pay for the costs of verifying the accuracy of the assessment procedure following a sampling procedure approved by HCFA.

7. All enrollment procedures are to be reviewed and approved by the project officer prior to initiation. This is to include, but not be limited to: numerical enrollment goals; specified open enrollment periods; accretion and deletion procedures; additional forms.

8. All marketing materials (brochures, media releases, fliers, etc.) and marketing plans are to be reviewed and approved in writing by the project officer before implementation.

9. The submission of an annual rate buildup and cost report which provides details on patient utilization and SHMO expenditures for both Medicare covered and noncovered services under the demonstration project.

10. SHMO must submit quarterly reports due 45 days after the end of each calendar quarter. HCFA will specify a uniform format for these quarterly reports which shall include a narrative section summarizing progress achieved and problems encountered and a statistical section which shall include data on enrollment, use, revenues and expenses, marketing, staffing and capacity changes, complaints and grievances, and quality assurance activities.

11. SHMO shall agree to provide or arrange for access to data required to perform an evaluation of all 3 years of the project. This project will be evaluated by HCFA using an independent evaluator. HCFA and ~~the~~ independent evaluator, with the advice of the SHMO, shall specify the data necessary to perform the evaluation. The SHMO shall agree to provide or arrange access to the following types of data: (1) enrollment and utilization data for a sample of Medicare-only and dually eligible (i.e., Medicare and Medicaid eligible) SHMO enrollees. This beneficiary-specific utilization data should include all services covered by the SHMO benefit package; (2) aggregate enrollment and utilization data for all SHMO enrollees; (3) data necessary for the SHMO to queue SHMO applicants and identify beneficiaries at-risk of institutionalization (i.e., data collected on the Health Status Information Form and Comprehensive Assessment Forms, and State-mandated nursing home certification forms); (4) data obtained through the SHMO's case-management information system for those SHMO enrollees who are case-managed as part of receiving expanded long-term care benefits; (5) administrative and project management data (e.g., a detailed chronology of significant project events, financial statements). The data specified above (i.e., nos. 1-5) shall be provided by the SHMO to HCFA or its evaluation contractor at <u>no cost</u> as a requirement of participating in the demonstration. The evaluator shall bear the cost of any special data collection efforts as specified by its contract with HCFA (e.g., surveys of beneficiaries, their families, or SHMO providers).

12. SHMO sites which require State licensure must receive certification and provide documentation to HCFA before implementation.

13. HCFA reserves the right to obtain reinsurance for the Medicare/Medicaid risk through the private sector, with the cost of the reinsurance premium distributed at 80 percent for Medicare and 20 percent for Medicaid. HCFA also reserves the right to provide additional funds to the site and require that the site purchase such reinsurance.

14. The rates for the second and third years of the demonstration will be constructed to reflect your actual experience relative to enrollees living in the community and at risk of institutionalization.

15. The State will share in the risk associated with Medicaid patients in the same ratio as other Medicaid costs.

Health Care Financing Administrati

6325 Security Boulevard
Baltimore, MD 21207

AUG 17 1984

Mr. John Selstad
Director
Medicare Partners
Suite 544
2829 University Avenue
Minneapolis, Minnesota 55414

Dear Mr. Selstad:

I am pleased to inform you that Medicare Partners has been approved as one of the four provider entities participating in the Health Care Financing Administration's (HCFA) Social/Health Maintenance Organization Demonstration (Grant No. 18-P-97604/1-05).

I have enclosed a list of the waivers and variances required for participation as a Social/Health Maintenance Organization provider. These waivers and variances are approved for the period beginning October 1, 1984 and ending March 31, 1988. Also enclosed is a list of Special Terms and Conditions associated with Medicare Partners' participation in the demonstration project. Final approval for participation in the project is contingent upon our receipt, within 30 days, of a written response accepting the enclosed Special Terms and Conditions.

Communications regarding programmatic aspects of the demonstration should be addressed to the HCFA project officer, Mr. John C. Sirmon, Room 2-D-4, Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207. His telephone number is (301) 594-5989.

I look forward to your participation and a successful implementation of this demonstration.

Sincerely yours,

David J. Butler
Acting Director
Office of Research and Demonstrations

Enclosures

## SPECIAL TERMS AND CONDITIONS

1. The demonstration will run for 42 months, with the first year defined as lasting 18 months.

2. Enrollment will not exceed 7500 Medicare beneficiaries.

3. The SHMO will be paid through December 31, 1984 at the 1984 AAPCC. HCFA anticipates that the 1985 AAPCC will be available mid-November. The 1985 AAPCC rates will be effective January 1, 1985.

4. No more than 5 percent of the SHMO members at enrollment will be "nursing home certifiable" and living in the community.

5. Within 120 days of award, the site shall submit for HCFA review and approval a phase-down plan which will describe how the site will ensure a smooth transition during the last year of the project. The phase-down plan must include a provision that no SHMO enrollment will be permitted during the last 9 months of the last year.

6. The site will pay for the costs of verifying the accuracy of the assessment procedure following a sampling procedure approved by HCFA.

7. All enrollment procedures are to be reviewed and approved by the project officer prior to initiation. This is to include, but not be limited to: numerical enrollment goals; specified open enrollment periods; accretion and deletion procedures; additional forms.

8. All marketing materials (brochures, media releases, fliers, etc.) and marketing plans are to be reviewed and approved in writing by the project officer before implementation.

9. The submission of an annual rate buildup and cost report which provides details on patient utilization and SHMO expenditures for both Medicare covered and noncovered services under the demonstration project.

10. SHMO must submit quarterly reports due 45 days after the end of each calendar quarter. HCFA will specify a uniform format for these quarterly reports which shall include a narrative section summarizing progress achieved and problems encountered and a statistical section which shall include data on enrollment, use, revenues and expenses, marketing, staffing and capacity changes, complaints and grievances, and quality assurance activities.

11. SHMO shall agree to provide or arrange for access to data required to perform an evaluation of all 3 years of the project. This project will be evaluated by HCFA using an independent evaluator. HCFA and the independent evaluator, with the advice of the SHMO, shall specify the data necessary to perform the evaluation. The SHMO shall agree to provide or arrange access to the following types of data: (1) enrollment and utilization data for a sample of Medicare-only and dually eligible (i.e., Medicare and Medicaid eligible) SHMO enrollees. This beneficiary-specific utilization data should include all services covered by the SHMO benefit package; (2) aggregate enrollment and utilization data for all SHMO enrollees; (3) data necessary for the SHMO to queue SHMO applicants and identify beneficiaries at-risk of institutionalization (i.e., data collected on the Health Status Information Form and Comprehensive Assessment Forms, and State-mandated nursing home certification forms); (4) data obtained through the SHMO's case-management information system for those SHMO enrollees who are case-managed as part of receiving expanded long-term care benefits; (5) administrative and project management data (e.g., a detailed chronology of significant project events, financial statements). The data specified above (i.e., nos. 1-5) shall be provided by the SHMO to HCFA or its evaluation contractor at <u>no cost</u> as a requirement of participating in the demonstration. The evaluator shall bear the cost of any special data collection efforts as specified by its contract with HCFA (e.g., surveys of beneficiaries, their families, or SHMO providers).

12. SHMO sites which require State licensure must receive certification and provide documentation to HCFA before implementation.

13. HCFA reserves the right to obtain reinsurance for the Medicare/Medicaid risk through the private sector, with the cost of the reinsurance premium distributed at 80 percent for Medicare and 20 percent for Medicaid. HCFA also reserves the right to provide additional funds to the site and require that the site purchase such reinsurance.

14. The rates for the second and third years of the demonstration will be constructed to reflect your actual experience relative to enrollees living in the community and at risk of institutionalization.

15. The State will share in the risk associated with Medicaid patients in the same ratio as other Medicaid costs.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administratio

6325 Security Boulevard
Baltimore, MD 21207

AUG 17 1984

Mr. William C. McMorran
Administrator
SCAN Health Plan
Suite 106
1045 Atlantic Avenue
Long Beach, California 90813

Dear Mr. McMorran:

I am pleased to inform you that SCAN Health Plan has been approved as one of the four provider entities participating in the Health Care Financing Administration's (HCFA) Social/Health Maintenance Organization Demonstration (Grant No. 18-P-97604/1-05).

I have enclosed a list of the waivers and variances required for participation as a Social/Health Maintenance Organization provider. These waivers and variances are approved for the period beginning October 1, 1984 and ending March 31, 1988. Also enclosed is a list of Special Terms and Conditions associated with SCAN Health Plan's participation in the demonstration project. Final approval for participation in the project is contingent upon our receipt, within 30 days, of a written response accepting the enclosed Special Terms and Conditions.

Communications regarding programmatic aspects of the demonstration should be addressed to the HCFA project officer, Mr. William D. Clark, Room 2-F-6, Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207. His telephone number is (301) 594-0093.

I look forward to your participation and a successful implementation of this demonstration.

Sincerely yours,

David J. Butler
Acting Director
Office of Research and Demonstrations

Enclosures

## SPECIAL TERMS AND CONDITIONS

1. The demonstration will run for 42 months, with the first year defined as lasting 18 months.

2. Enrollment will not exceed 7500 Medicare beneficiaries.

3. The SHMO will be paid through December 31, 1984 at the 1984 AAPCC. HCFA anticipates that the 1985 AAPCC will be available mid-November. The 1985 AAPCC rates will be effective January 1, 1985.

4. No more than 5 percent of the SHMO members at enrollment will be "nursing home certifiable" and living in the community.

5. Within 120 days of award, the site shall submit for HCFA review and approval a phase-down plan which will describe how the site will ensure a smooth transition during the last year of the project. The phase-down plan must include a provision that no SHMO enrollment will be permitted during the last 9 months of the last year.

6. The site will pay for the costs of verifying the accuracy of the assessment procedure following a sampling procedure approved by HCFA.

7. All enrollment procedures are to be reviewed and approved by the project officer prior to initiation. This is to include, but not be limited to: numerical enrollment goals; specified open enrollment periods; accretion and deletion procedures; additional forms.

8. All marketing materials (brochures, media releases, fliers, etc.) and marketing plans are to be reviewed and approved in writing by the project officer before implementation.

9. The submission of an annual rate buildup and cost report which provides details on patient utilization and SHMO expenditures for both Medicare covered and noncovered services under the demonstration project.

10. SHMO must submit quarterly reports due 45 days after the end of each calendar quarter. HCFA will specify a uniform format for these quarterly reports which shall include a narrative section summarizing progress achieved and problems encountered and a statistical section which shall include data on enrollment, use, revenues and expenses, marketing, staffing and capacity changes, complaints and grievances, and quality assurance activities.

11. SHMO shall agree to provide or arrange for access to data required to perform an evaluation of all 3 years of the project. This project will be evaluated by HCFA using an independent evaluator. HCFA and ~~the~~ independent evaluator, with the advice of the SHMO, shall specify the data necessary to perform the evaluation. The SHMO shall agree to provide or arrange access to the following types of data: (1) enrollment and utilization data for a sample of Medicare-only and dually eligible (i.e., Medicare and Medicaid eligible) SHMO enrollees. This beneficiary-specific utilization data should include all services covered by the SHMO benefit package; (2) aggregate enrollment and utilization data for all SHMO enrollees; (3) data necessary for the SHMO to queue SHMO applicants and identify beneficiaries at-risk of institutionalization (i.e., data collected on the Health Status Information Form and Comprehensive Assessment Forms, and State-mandated nursing home certification forms); (4) data obtained through the SHMO's case-management information system for those SHMO enrollees who are case-managed as part of receiving expanded long-term care benefits; (5) administrative and project management data (e.g., a detailed chronology of significant project events, financial statements). The data specified above (i.e., nos. 1-5) shall be provided by the SHMO to HCFA or its evaluation contractor at no cost as a requirement of participating in the demonstration. The evaluator shall bear the cost of any special data collection efforts as specified by its contract with HCFA (e.g., surveys of beneficiaries, their families, or SHMO providers).

12. SHMO sites which require State licensure must receive certification and provide documentation to HCFA before implementation.

13. HCFA reserves the right to obtain reinsurance for the Medicare/Medicaid risk through the private sector, with the cost of the reinsurance premium distributed at 80 percent for Medicare and 20 percent for Medicaid. HCFA also reserves the right to provide additional funds to the site and require that the site purchase such reinsurance.

14. The rates for the second and third years of the demonstration will be constructed to reflect your actual experience relative to enrollees living in the community and at risk of institutionalization.

15. The State will share in the risk associated with Medicaid patients in the same ratio as other Medicaid costs.

6325 Security Boulevard
Baltimore, MD 21207

AUG 17 1984

Merwyn Greenlick, Ph.D.
Kaiser-Permanente
Health Services Research Center
4610 Southeast Belmont Street
Portland, Oregon 97215

Dear Dr. Greenlick:

I am pleased to inform you that Kaiser-Permanente has been approved as one of the four provider entities participating in the Health Care Financing Administration's (HCFA) Social/Health Maintenance Organization Demonstration (Grant No. 18-P-97604/1-05).

I have enclosed a list of the waivers and variances required for participation as a Social/Health Maintenance Organization provider. These waivers and variances are approved for the period beginning October 1, 1984 and ending March 31, 1988. Also enclosed is a list of Special Terms and Conditions associated with Kaiser-Permanente's participation in the demonstration project. Final approval for participation in the project is contingent upon our receipt, within 30 days, of a written response accepting the enclosed Special Terms and Conditions.

Communications regarding programmatic aspects of the demonstration should be addressed to the HCFA project officer, Ms. Nancy Row, Room 2-D-4, Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207. Her telephone number is (301) 594-1968.

I look forward to your participation and a successful implementation of this demonstration.

Sincerely yours,

David J. Butler
Acting Director
Office of Research and Demonstrations

Enclosures

## SPECIAL TERMS AND CONDITIONS

1. The demonstration will run for 42 months, with the first year defined as lasting 18 months.

2. Enrollment will not exceed 7500 Medicare beneficiaries.

3. The SHMO will be paid through December 31, 1984 at the 1984 AAPCC. HCFA anticipates that the 1985 AAPCC will be available mid-November. The 1985 AAPCC rates will be effective January 1, 1985.

4. No more than 5 percent of the SHMO members at enrollment will be "nursing home certifiable" and living in the community.

5. Within 120 days of award, the site shall submit for HCFA review and approval a phase-down plan which will describe how the site will ensure a smooth transition during the last year of the project. The phase-down plan must include a provision that no SHMO enrollment will be permitted during the last 9 months of the last year.

6. The site will pay for the costs of verifying the accuracy of the assessment procedure following a sampling procedure approved by HCFA.

7. All enrollment procedures are to be reviewed and approved by the project officer prior to initiation. This is to include, but not be limited to: numerical enrollment goals; specified open enrollment periods; accretion and deletion procedures; additional forms.

8. All marketing materials (brochures, media releases, fliers, etc.) and marketing plans are to be reviewed and approved in writing by the project officer before implementation.

9. The submission of an annual rate buildup and cost report which provides details on patient utilization and SHMO expenditures for both Medicare covered and noncovered services under the demonstration project.

10. SHMO must submit quarterly reports due 45 days after the end of each calendar quarter. HCFA will specify a uniform format for these quarterly reports which shall include a narrative section summarizing progress achieved and problems encountered and a statistical section which shall include data on enrollment, use, revenues and expenses, marketing, staffing and capacity changes, complaints and grievances, and quality assurance activities.

11. SHMO shall agree to provide or arrange for access to data required to perform an evaluation of all 3 years of the project. This project will be evaluated by HCFA using an independent evaluator. HCFA and ~~the~~ independent evaluator, with the advice of the SHMO, shall specify the data necessary to perform the evaluation. The SHMO shall agree to provide or arrange access to the following types of data: (1) enrollment and utilization data for a sample of Medicare-only and dually eligible (i.e., Medicare and Medicaid eligible) SHMO enrollees. This beneficiary-specific utilization data should include all services covered by the SHMO benefit package; (2) aggregate enrollment and utilization data for all SHMO enrollees; (3) data necessary for the SHMO to queue SHMO applicants and identify beneficiaries at-risk of institutionalization (i.e., data collected on the Health Status Information Form and Comprehensive Assessment Forms, and State-mandated nursing home certification forms); (4) data obtained through the SHMO's case-management information system for those SHMO enrollees who are case-managed as part of receiving expanded long-term care benefits; (5) administrative and project management data (e.g., a detailed chronology of significant project events, financial statements). The data specified above (i.e., nos. 1-5) shall be provided by the SHMO to HCFA or its evaluation contractor at no cost as a requirement of participating in the demonstration. The evaluator shall bear the cost of any special data collection efforts as specified by its contract with HCFA (e.g., surveys of beneficiaries, their families, or SHMO providers).

12. SHMO sites which require State licensure must receive certification and provide documentation to HCFA before implementation.

13. HCFA reserves the right to obtain reinsurance for the Medicare/Medicaid risk through the private sector, with the cost of the reinsurance premium distributed at 80 percent for Medicare and 20 percent for Medicaid. HCFA also reserves the right to provide additional funds to the site and require that the site purchase such reinsurance.

14. The rates for the second and third years of the demonstration will be constructed to reflect your actual experience relative to enrollees living in the community and at risk of institutionalization.

Health Care Financing Administrat

6325 Security Boulevard
Baltimore, MD 21207

AUG 17 1984

Mr. Leonard W. Levine
Commissioner
Department of Human Services
Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Dear Mr. Levine:

I am pleased to inform you that your application No. 11-P-98255/5-01, "Ebenezer Society and Group Health Plan, Inc.--A Social/Health Maintenance Organization Demonstration Project--A Waiver-Only Demonstration," has been approved by the Health Care Financing Administration (HCFA) for the period October 1, 1984 through March 31, 1988. Final approval for participation in the project is contingent upon our receipt, within 30 days, of a written response accepting the Special Terms and Conditions attached to the enclosed Notice of Grant Award.

Under the authority of Section 1115(a)(1) of the Social Security Act, the requisite waivers of Title XIX and their corresponding regulations have been approved for the grant period, subject to annual renewal by HCFA. I have enclosed a list of the approved waivers. In addition, under the authority of Section 1115(a)(2) of the Social Security Act, expenditures made by the State for the items identified on the enclosed list (which are not otherwise included as expenditures under section 1903) shall, for the period of this demonstration, be regarded as expenditures under the State's Title XIX plan.

All official correspondence, quarterly and annual reports should be submitted to Mr. William C. Pembleton, Grants Officer, Project Grants Branch, Room 389 East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207. Communications relating to programmatic matters should be directed to the HCFA Project Officer, Mr. John C. Sirmon, Room 2-D-4, Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207. His telephone number is (301) 594-5989.

Sincerely yours,

David J. Butler
Acting Director
Office of Research and Demonstrations

Enclosures

cc:
Mr. John Selstad, Medicare Partners

Health Care Financing Administration

# NOTICE OF GRANT AWARD

ıder authority of Section 1115 (a)(1) SSA

(Legislation) (Regulations)

is grant is subject to the terms and conditions incorporated either directly or by erence in:

a. Grant Program Legislation cited above.
b. Grant Program Regulations cited above.
c. Special Terms and Conditions, if any, noted below.
d. HCFA Project Grants Policy Handbook in affect as of beginning date of grant budget period.
e. 45 CFR Part 74

1. DOCUMENT NO. 05-0011P98255
CFDA NO. 13.766
2. GRANT NO. 11-P-98255/5-01
3. AMEND. NO.
4. BUDGET PERIOD FROM 10/1/84 THROUGH 3/31/86
5. TOTAL PROJECT PERIOD: FROM 10/1/84 THROUGH 3/31/88
6. TYPE OF GRANT
☐ NON-COMPETING CONTINUATION  XX NEW  ☐ SUPPLEMENT  ☐ COMPETING CONTINUATION
☐ REVISION FOR ( ) See Reverse for explanation.

PROJECT/PROGRAM TITLE

Ebenezer Society and Group Health Plan, Inc.

GRANTEE ORGANIZATION

ıte of Minnesota
ıartment of Human Services
ıtennial Office Building
Paul, MN 55155

9. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR

Mr. Leonard W. Levine
Commissioner

10. APPROVED BUDGET

ANT FUNDS ONLY ☐  TOTAL PROJECT COSTS ☐

| | |
|---|---|
| ISONNEL | $ |
| NGE BENEFITS | |
| AVEL | |
| JIPMENT | |
| PLIES | |
| ITRACTUAL | |
| IER | |
| ECT COSTS | $ |
| IRECT COSTS | |
| ulated at ____ % of $____ | |
| AL APPROVED BUDGET | $ NA |

12. CONGR. DISTRICT statewide
13. COUNTY Ramsey

14. AWARD COMPUTATION

A. TOTAL APPROVED BUDGET $ NA
B. LESS ________ $
C. LESS UNOBLIGATED BALANCE FROM PRIOR BUDGET PERIOD(s) $
D. TOTAL AMOUNT AWARDED THIS BUDGET PERIOD $ NA

15. AMOUNT AWARDED—THIS ACTION $ NA

16. TOTAL FEDERAL FUNDS AWARDED TO DATE FOR PROJECT PERIOD $ NA

17. SUPPORT RECOMMENDED FOR REMAINDER OF PROJECT PERIOD

| PERIOD | TOTAL DIRECT COSTS |
|---|---|
| -02 yr | Waiver Only |
| -03 yr | Waiver Only |
| -04 yr | None |

REQUIRED GRANTEE PARTICIPATION

REMARKS (SPECIAL TERMS & CONDITIONS ATTACHED XX YES ☐ NO)

PAYMENT INFORMATION: PAYMENTS UNDER THIS AWARD WILL BE MADE UNDER PAYMENT CLAUSE NA AS EXPLAINED ON REVERSE.

INQUIRIES REGARDING ADMINISTRATION OF THIS GRANT SHOULD BE DIRECTED TO

[redacted].John C. Sirmon (301) 594-5989 OR Paul G. McKeown (301) 594-3342
(HCFA PROJECT OFFICER)  HCFA GRANTS MANAGEMENT SPECIALIST

FY CAN NA
22. CRS-EIN NA
OBJECT CLASS NA
24. HCFA LIST NO. NA

25. SIGNATURE AND TITLE—HCFA OFFICIAL
DATE 1/17/85
William C. Pembleton, Grants Officer

HCFA 6-U6-PG (9-77)

# STATEMENT OF SPECIAL TERMS AND CONDITIONS

Grant No. : 11-P-98255/5-01

Title : Ebenezer Society and Group Health Plan, Inc.--A Social/ Health Maintenance Organization Demonstration Project--A Waiver-Only Demonstration

Grantee : Minnesota Department of Public Welfare

The following terms and conditions apply to this grant:

1. The State will submit quarterly and annual reports to HCFA.

2. The State shall agree to provide or arrange for access to data required to perform an evaluation of all 3 years of the project. The project will be evaluated by HCFA using an independent evaluator. HCFA and the independent evaluator, with the advice of the SHMO, shall specify the data necessary to perform the evaluation. The State shall agree to provide or arrange access to the following types of data: (1) enrollment and utilization data for a sample of dually eligible (i.e., Medicare and Medicaid eligible) SHMO enrollees prior to enrolling in the SHMO and eligibility and utilization data for a sample of dually eligible beneficiaries who do not enroll in the SHMO (i.e., nonenrollee comparison group). This beneficiary-specific utilization data shall include all Medicaid covered services that are part of the SHMO benefit package; (2) data necessary for the State to certify nursing home placement for any comparison group beneficiary or SHMO enrollee who is placed in a nursing home during the 3-year data collection period; (3) administrative and project management data (e.g., a detailed chronology of significant project events); (4) data related to project costs and savings. The State shall provide access to or copies of required data that are routinely collected at no cost to the evaluator. The evaluator shall bear the cost of any special data collection efforts as specified by its contract with HCFA (e.g., surveys of beneficiaries, their families, or SHMO providers).

3. The State shall submit their rates (with a detailed description of the methodology) for HCFA review and approval each year of the project 90 days before the effective date.

4. The rates for the second and third years of the demonstration will be constructed to reflect your actual experience relative to enrollees living in the community and at risk of institutionalization.

5. The state will share in the risk associated with Medicaid patients in the same ratio as other Medicaid costs.

ing Administr

6325 Security Boulevard
Baltimore, MD 21207

AUG 17 1984

Mr. Peter Rank
Director
Department of Health Services
Room 1253
714 P Street
Sacramento, California 95814

Dear Mr. Rank:

I am pleased to inform you that your application No. 11-P-98240/9-01, "SCAN Health Plan--A Social/Health Maintenance Organization Demonstration Project--A Waiver-Only Demonstration," has been approved by the Health Care Financing Administration (HCFA) for the period October 1, 1984 through March 31, 1988. Final approval for participation in the project is contingent upon our receipt, within 30 days, of a written response accepting the Special Terms and Conditions attached to the enclosed Notice of Grant Award.

Under the authority of Section 1115(a)(1) of the Social Security Act, the requisite waivers of Title XIX and their corresponding regulations have been approved for the grant period, subject to annual renewal by HCFA. I have enclosed a list of the approved waivers. In addition, under the authority of Section 1115(a)(2) of the Social Security Act, expenditures made by the State for the items identified on the enclosed list (which are not otherwise included as expenditures under section 1903) shall, for the period of this demonstration, be regarded as expenditures under the State's Title XIX plan.

All official correspondence, quarterly and annual reports should be submitted to Mr. William C. Pembleton, Grants Officer, Project Grants Branch, Room 389 East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207. Communications relating to programmatic matters should be directed to the HCFA Project Officer, Mr. William D. Clark, Room 2-F-6, Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207. His telephone number is (301) 594-0093.

Sincerely yours,

David J. Butler
Acting Director
Office of Research and Demonstrations

Enclosures

cc:
Mr. William McMorran
Mr. Jay Greenburg, Sc.D.
Ms. Mary Griffen

Health Care Financing Administration

# NOTICE OF GRANT AWARD

1. DOCUMENT NO. 05-0011P98240
CFDA NO. 13.766
2. GRANT NO. 11-P-98240/9-01
3. AMEND. NO.

Under authority of Section 1115 (a)(1) SSA
(Legislation) (Regulations)

This grant is subject to the terms and conditions incorporated either directly or by reference in:

a. Grant Program Legislation cited above.
b. Grant Program Regulations cited above.
c. Special Terms and Conditions, if any, noted below.
d. HCFA Project Grants Policy Handbook in effect as of beginning date of grant budget period.
e. 45 CFR Part 74

4. BUDGET PERIOD FROM 10/1/84 THROUGH 3/31/86
5. TOTAL PROJECT PERIOD: FROM 10/1/84 THROUGH 3/31/88
6. TYPE OF GRANT
☐ NON-COMPETING CONTINUATION ☒ NEW ☐ COMPETING CONTINUATION
☐ SUPPLEMENT
☐ REVISION FOR ( ) See Reverse for explanation.

7. PROJECT/PROGRAM TITLE
SCAN Health Plan: A Social Health Maintenance Organization

8. GRANTEE ORGANIZATION
State of California
Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814

9. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR
Mr. Peter Rank
Director

10. APPROVED BUDGET
GRANT FUNDS ONLY ☐ TOTAL PROJECT COSTS ☐

| | |
|---|---|
| PERSONNEL | $ |
| FRINGE BENEFITS | |
| TRAVEL | |
| EQUIPMENT | |
| SUPPLIES | |
| CONTRACTUAL | |
| OTHER | |
| DIRECT COSTS | $ |
| INDIRECT COSTS | |
| calculated at ___ % of $____ | |
| TOTAL APPROVED BUDGET | $ NA |

12. CONGR. DISTRICT: Citywide
13. COUNTY: Sacramento

14. AWARD COMPUTATION

| | |
|---|---|
| A. TOTAL APPROVED BUDGET | $ NA |
| B. LESS | $ |
| C. LESS UNOBLIGATED BALANCE FROM PRIOR BUDGET PERIOD(s) | $ |
| D. TOTAL AMOUNT AWARDED THIS BUDGET PERIOD | $ NA |

15. AMOUNT AWARDED—THIS ACTION $ NA

16. TOTAL FEDERAL FUNDS AWARDED TO DATE FOR PROJECT PERIOD $ NA

17. SUPPORT RECOMMENDED FOR REMAINDER OF PROJECT PERIOD

| PERIOD | TOTAL DIRECT COSTS |
|---|---|
| 02 yr | Waiver Only |
| 03 yr | Waiver Only |
| 04 yr | None |

11. REQUIRED GRANTEE PARTICIPATION

REMARKS (SPECIAL TERMS & CONDITIONS ATTACHED XX YES ☐ NO)

PAYMENT INFORMATION: PAYMENTS UNDER THIS AWARD WILL BE MADE UNDER PAYMENT CLAUSE NA AS EXPLAINED ON REVERSE.

INQUIRIES REGARDING ADMINISTRATION OF THIS GRANT SHOULD BE DIRECTED TO:
William D. Clark (301) 594-0093 (HCFA PROJECT OFFICER) OR Paul G. McKeown (301) 594-3342 (HCFA GRANTS MANAGEMENT SPECIALIST)

| | |
|---|---|
| FY CAN: NA | 22. CRS/EIN: NA |
| OBJECT CLASS: NA | 24. HCFA LIST NO.: NA |

25. SIGNATURE AND TITLE—HCFA OFFICIAL
DATE 4/17/84
William C. Pembleton, Grants Officer

Form HCFA 6-U6-PG (9-77)

# STATEMENT OF SPECIAL TERMS AND CONDITIONS

Grant No. : 11-P-98240/9-01

Title : SCAN Health Plan--A Social/Health Maintenance Organization Demonstration Project--A Waiver-Only Demonstration

Grantee : Department of Health Services
Sacramento, California

The following terms and conditions apply to this grant:

1. The State will submit quarterly and annual reports to HCFA.

2. The State shall agree to provide or arrange for access to data required to perform an evaluation of all 3 years of the project. The project will be evaluated by HCFA using an independent evaluator. HCFA and the independent evaluator, with the advice of the SHMO, shall specify the data necessary to perform the evaluation. The State shall agree to provide or arrange access to the following types of data: (1) enrollment and utilization data for a sample of dually eligible (i.e., Medicare and Medicaid eligible) SHMO enrollees prior to enrolling in the SHMO and eligibility and utilization data for a sample of dually eligible beneficiaries who do not enroll in the SHMO (i.e., nonenrollee comparison group). This beneficiary-specific utilization data shall include all Medicaid covered services that are part of the SHMO benefit package; (2) data necessary for the State to certify nursing home placement for any comparison group beneficiary or SHMO enrollee who is placed in a nursing home during the 3-year data collection period; (3) administrative and project management data (e.g., a detailed chronology of significant project events); (4) data related to project costs and savings. The State shall provide access to or copies of required data that are routinely collected at no cost to the evaluator. The evaluator shall bear the cost of any special data collection efforts as specified by its contract with HCFA (e.g., surveys of beneficiaries, their families, or SHMO providers).

3. The State shall submit their rates (with a detailed description of the methodology) for HCFA review and approval each year of the project 90 days before the effective date.

4. The rates for the second and third years of the demonstration will be constructed to reflect your actual experience relative to enrollees living in the community and at risk of institutionalization.

5. The state will share in the risk associated with Medicaid patients in the same ratio as other Medicaid costs.

...ing Administra

6325 Security Boulevard
Baltimore, MD 21207

AUG 17 1984

Mr. Cesar Perales
Commissioner
New York State Department of
Social Services
40 North Pearl Street
Albany, New York 12243

Dear Mr. Perales:

I am pleased to inform you that your application No. 11-P-98145/2-01, "Elderly Care--A Social/Health Maintenance Organization Demonstration Project--A Waiver-Only Demonstration," has been approved by the Health Care Financing Administration (HCFA) for the period October 1, 1984 through March 31, 1988. Final approval for participation in the project is contingent upon our receipt, within 30 days, of a written response accepting the Special Terms and Conditions attached to the enclosed Notice of Grant Award.

Under the authority of Section 1115(a)(1) of the Social Security Act, the requisite waivers of Title XIX and their corresponding regulations have been approved for the grant period, subject to annual renewal by HCFA. I have enclosed a list of the approved waivers. In addition, under the authority of Section 1115(a)(2) of the Social Security Act, expenditures made by the State for the items identified on the enclosed list (which are not otherwise included as expenditures under section 1903) shall, for the period of this demonstration, be regarded as expenditures under the State's Title XIX plan.

All official correspondence, quarterly and annual reports should be submitted to Mr. William C. Pembleton, Grants Officer, Project Grants Branch, Room 389 East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207. Communications relating to programmatic matters should be directed to the HCFA Project Officer, Mr. William D. Clark, Room 2-F-6, Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207. His telephone number is (301) 594-0093.

Sincerely yours,

David J. Butler
Acting Director
Office of Research and Demonstrations

Enclosures

cc:
Mr. Dennis Kodner
Mr. Jay Greenburg, Sc.D.
Ms. Barbara Frankel

05-0011P98145 | 13.766

# NOTICE OF GRANT AWARD

Under authority of Section 1115(a)(1) SSA

(Legislation) (Regulations)

This grant is subject to the terms and conditions incorporated either directly or by reference in:

a. Grant Program Legislation cited above.
b. Grant Program Regulations cited above.
c. Special Terms and Conditions, if any, noted below.
d. HCFA Project Grants Policy Handbook in effect as of beginning date of grant budget period.
e. 45 CFR Part 74

2. GRANT NO. 11-P-98145/2-01

3. AMEND. NO.

4. BUDGET PERIOD FROM 10/1/84 THROUGH 3/31/86

5. TOTAL PROJECT PERIOD: FROM 10/1/84 THROUGH 3/31/88

6. TYPE OF GRANT
☐ NON-COMPETING CONTINUATION ☒ NEW ☐ COMPETING CONTINUATION
☐ SUPPLEMENT
☐ REVISION FOR ( ) See Reverse for explanation.

PROJECT/PROGRAM TITLE

"Elder Care: A Social/Health Maintenance Organization

GRANTEE ORGANIZATION

New York State Dept of Social Services
Division of Medical Assistance
40 North Pearl Street
Albany, New York 12243

9. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR

Mr. Cesar Perales
Commissioner

10. APPROVED BUDGET

GRANT FUNDS ONLY ☐ TOTAL PROJECT COSTS ☐

| | |
|---|---|
| PERSONNEL | $ |
| FRINGE BENEFITS | |
| TRAVEL | |
| EQUIPMENT | |
| SUPPLIES | |
| CONTRACTUAL | |
| OTHER | |
| DIRECT COSTS | $ |
| INDIRECT COSTS | |
| Calculated at ____ % of $____ | |
| TOTAL APPROVED BUDGET | $ NA |

REQUIRED GRANTEE PARTICIPATION

12. CONGR. DISTRICT: 28th

13. COUNTY: Albany

14. AWARD COMPUTATION

| | |
|---|---|
| A. TOTAL APPROVED BUDGET | $ NA |
| B. LESS | $ |
| C. LESS UNOBLIGATED BALANCE FROM PRIOR BUDGET PERIOD(s) | $ |
| D. TOTAL AMOUNT AWARDED THIS BUDGET PERIOD | $ NA |

15. AMOUNT AWARDED—THIS ACTION $ NA

16. TOTAL FEDERAL FUNDS AWARDED TO DATE FOR PROJECT PERIOD $ NA

17. SUPPORT RECOMMENDED FOR REMAINDER OF PROJECT PERIOD

| PERIOD | TOTAL DIRECT COSTS |
|---|---|
| 02 yr | Waiver Only |
| 03 yr | Waiver Only |
| 04 yr | None |

REMARKS (SPECIAL TERMS & CONDITIONS ATTACHED ☒ YES ☐ NO)

PAYMENT INFORMATION: PAYMENTS UNDER THIS AWARD WILL BE MADE UNDER PAYMENT CLAUSE NA AS EXPLAINED ON REVERSE.

INQUIRIES REGARDING ADMINISTRATION OF THIS GRANT SHOULD BE DIRECTED TO:

William D. Clark (301) 594-0093 (HCFA PROJECT OFFICER) OR Paul G. McKeown (301) 594-3348 (HCFA GRANTS MANAGEMENT SPECIALIST)

| | | |
|---|---|---|
| FY CAN: NA | 22. CRS/EIN: NA | 25. SIGNATURE AND TITLE—HCFA OFFICIAL DATE 2/17/84 |
| OBJECT CLASS: NA | 24. HCFA LIST NO.: NA | William C.Pembleton, Grants Officer |

Form HCFA 6-U6-PG (9-77)

2 — PROJECT/PROGRAM DIRECTOR

# STATEMENT OF SPECIAL TERMS AND CONDITIONS

Grant No. : 11-P-98145/2-01

Title : Elderly Care--A Social/Health Maintenance Organization Demonstration Project--A Waiver-Only Demonstration

Grantee : New York State Department of Social Services

The following terms and conditions apply to this grant:

1. The State will submit quarterly and annual reports to HCFA.

2. The State shall agree to provide or arrange for access to data required to perform an evaluation of all 3 years of the project. The project will be evaluated by HCFA using an independent evaluator. HCFA and the independent evaluator, with the advice of the SHMO, shall specify the data necessary to perform the evaluation. The State shall agree to provide or arrange access to the following types of data: (1) enrollment and utilization data for a sample of dually eligible (i.e., Medicare and Medicaid eligible) SHMO enrollees prior to enrolling in the SHMO and eligibility and utilization data for a sample of dually eligible beneficiaries who do not enroll in the SHMO (i.e., nonenrollee comparison group). This beneficiary-specific utilization data shall include all Medicaid covered services that are part of the SHMO benefit package; (2) data necessary for the State to certify nursing home placement for any comparison group beneficiary or SHMO enrollee who is placed in a nursing home during the 3-year data collection period; (3) administrative and project management data (e.g., a detailed chronology of significant project events); (4) data related to project costs and savings. The State shall provide access to or copies of required data that are routinely collected at no cost to the evaluator. The evaluator shall bear the cost of any special data collection efforts as specified by its contract with HCFA (e.g., surveys of beneficiaries, their families, or SHMO providers).

3. The State shall submit their rates (with a detailed description of the methodology) for HCFA review and approval each year of the project 90 days before the effective date.

4. The rates for the second and third years of the demonstration will be constructed to reflect your actual experience relative to enrollees living in the community and at risk of institutionalization.

5. The state will share in the risk associated with Medicaid patients in the same ratio as other Medicaid costs.